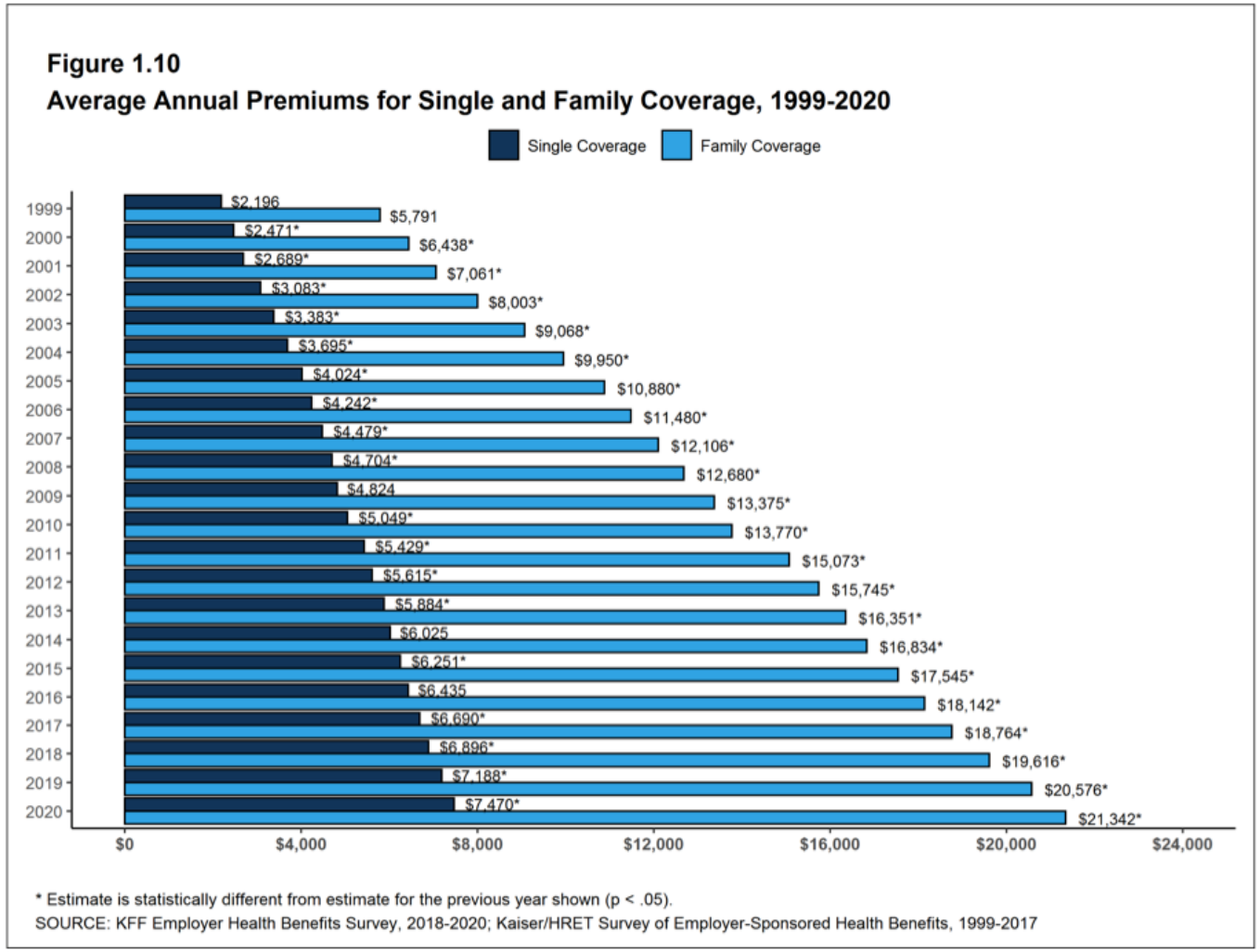
Future of Rural Healthcare: Vermont Vision 2030

June 23, 2021

Eric K. Shell, MBA, Chairman

STROUDWATER

Call to Action: Insurance Premiums



KFF

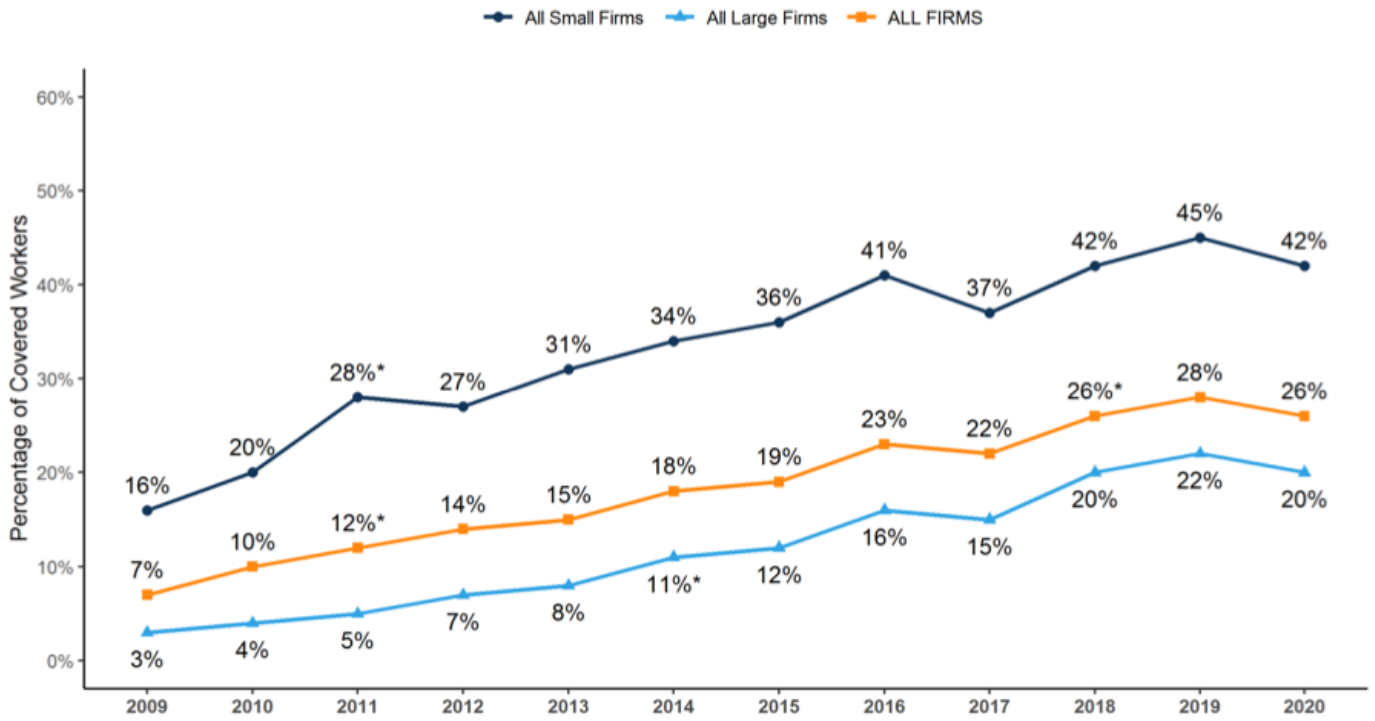
Employer Health Benefits

2020

Annual Survey

Call to Action: Growth of High Deductible Plans

Figure E
Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $2,000 or More for Single Coverage, by Firm Size, 2009-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

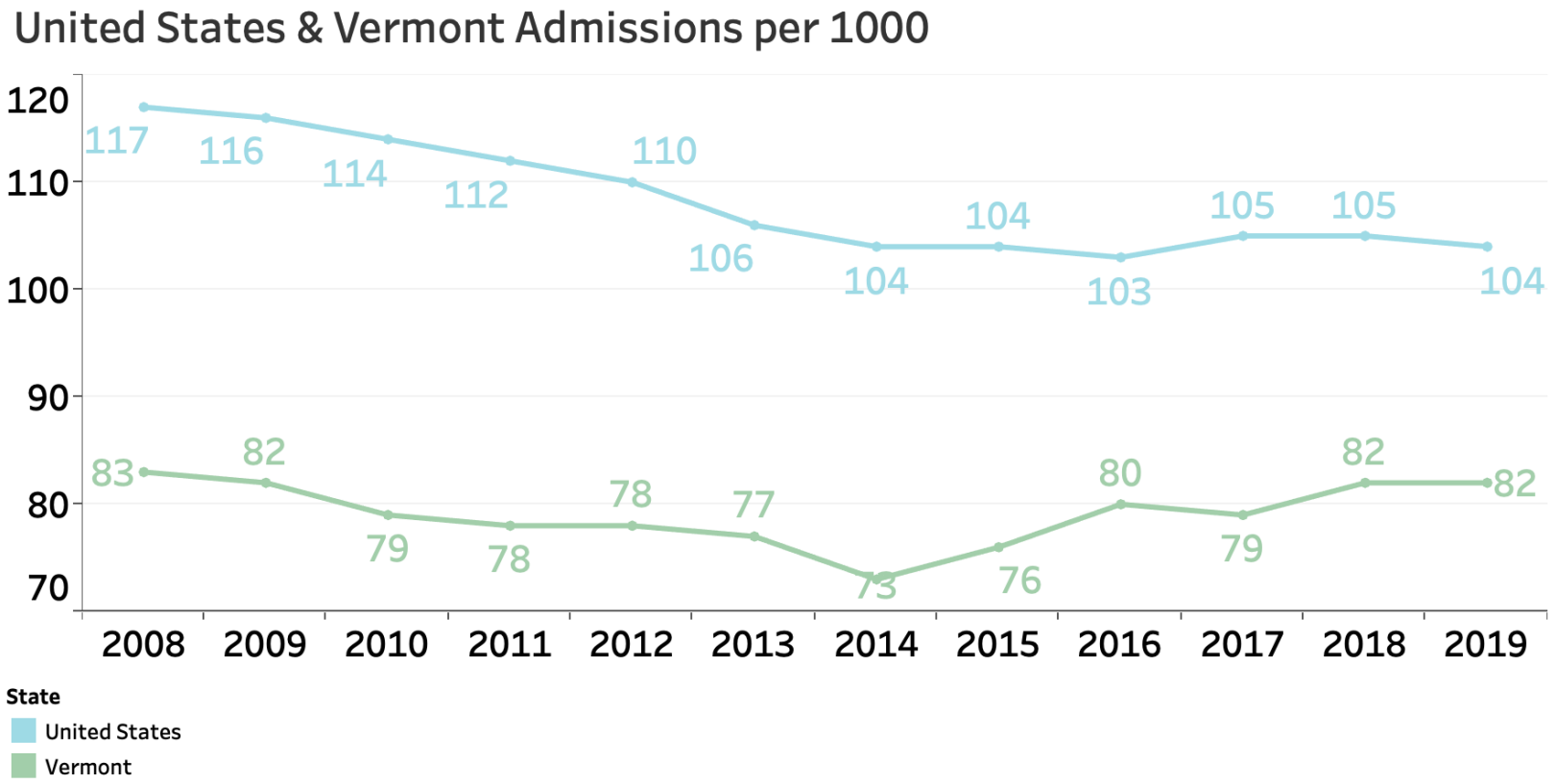
KFF

Employer Health Benefits

2020

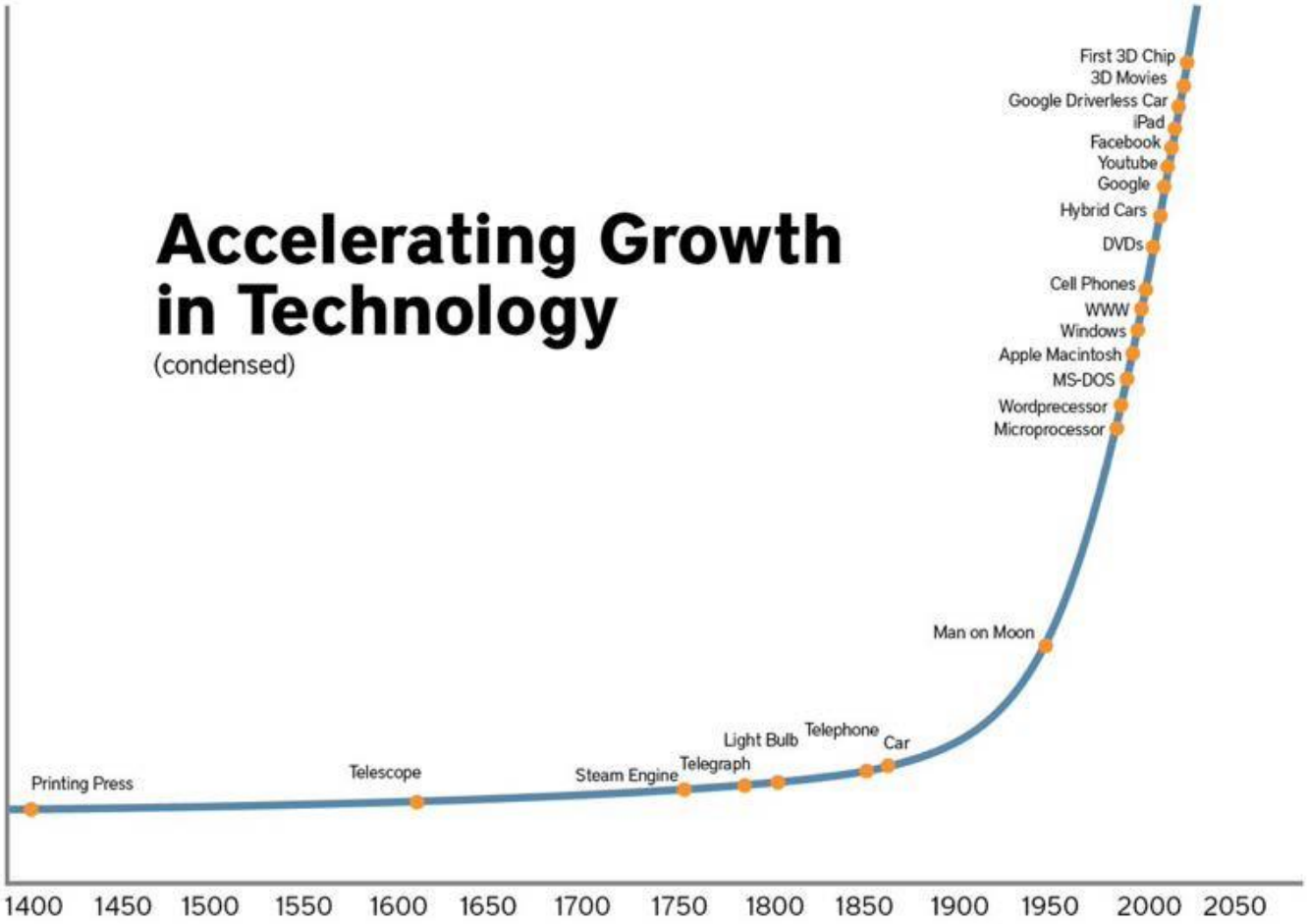
Annual Survey

Call to Action – Declining IP Volume



Source:KFF.org
Data are for community hospitals, which represent 85% of all hospitals. Federal hospitals, long term care hospitals, psychiatric hospitals, institutions for the mentally retarded, and alcoholism and other chemical dependency hospitals are not included.

Call to action: Advances in Technology



Source: Khalid Hamdan, Accelerating Growth in Technology

Call to Action: UnitedHealth Buys OptumCare (4/23/21)

Managed care company UnitedHealth Group has purchased OptumCare, which comprises 56,000 physicians and 1600 clinics, and plans to grow it to a $100B business through value-based arrangements.

Per OptumHealth (OptumCare parent) CEO Dr. Wyatt Decker, under the new arrangement, physicians will be paid to keep patients healthy instead of for treating them when they are sick.

OptumCare is also launching a virtual care platform called Optum Virtual Care that supports its plan to integrate virtual care, home care, and care clinics across all 50 states.

"When you begin to pencil out the math, as we move people into value-based arrangements, that will be a major driver of how we'll move to a $100 billion book of business."

OptumHealth CEO Wyatt Decker, MD

Source: Becker's Hospital Review, *How UnitedHealth plans to make Optum a $100B business,* Ayla Ellison, April 23, 2021, https://www.beckershospitalreview.com/finance/how-unitedhealth-plans-to-make-optum-a-100b-business.html?origin=CIOE

Call to Action: CVS Targets 65B Healthcare Interactions by 2030

- CVS continues its expansion into retail healthcare, setting a goal to facilitate 65 billion healthcare interactions over the next 10 years
- Key strategies include
  - Continuing to grow HealthHUB stores
  - Rethinking care delivery based on lessons learned during COVID-19
  - Investing in community health
- CVS opened 650 HealthHUBs in 2020 and is on track to reach 1500 by the end of 2021
  - HealthHUB stores offer both in-person and virtual services.
- CVS grew during the pandemic, becoming the largest private provider of COVID-19 testing and providing over 20k visits at its newly launched telehealth platform E-clinic

Source: FierceHealthcare, *CVS wants to facilitate 65B healthcare interactions by 2030. Here's how,* Paige Minemyer, 3/31/21 https://www.fiercehealthcare.com/payer/cvs-wants-to-facilitate-65b-healthcare-interactions-by-2030-here-s-how

Call to Action: Walmart Telehealth Offering with MeMD Acquisition

- Joining other major retailers such as CVS and Amazon, Walmart has acquired telehealth provider MeMD to expand its telehealth services.
- The acquisition is still pending regulatory approval.
- Founded in 2010, MeMD currently provides medical and mental health visits to 5 million members across the U.S.
- Among other healthcare ventures, Walmart currently operates and/or provides:
  - Walmart Health Centers within its stores
  - Freestanding health centers in Georgia, Texas, Arkansas and Chicago
  - Direct-to-consumer telehealth through purchased app Ro
  - Telehealth partnership with Doctor on Demand to offer services to its 1.3 million workers at a reduced price

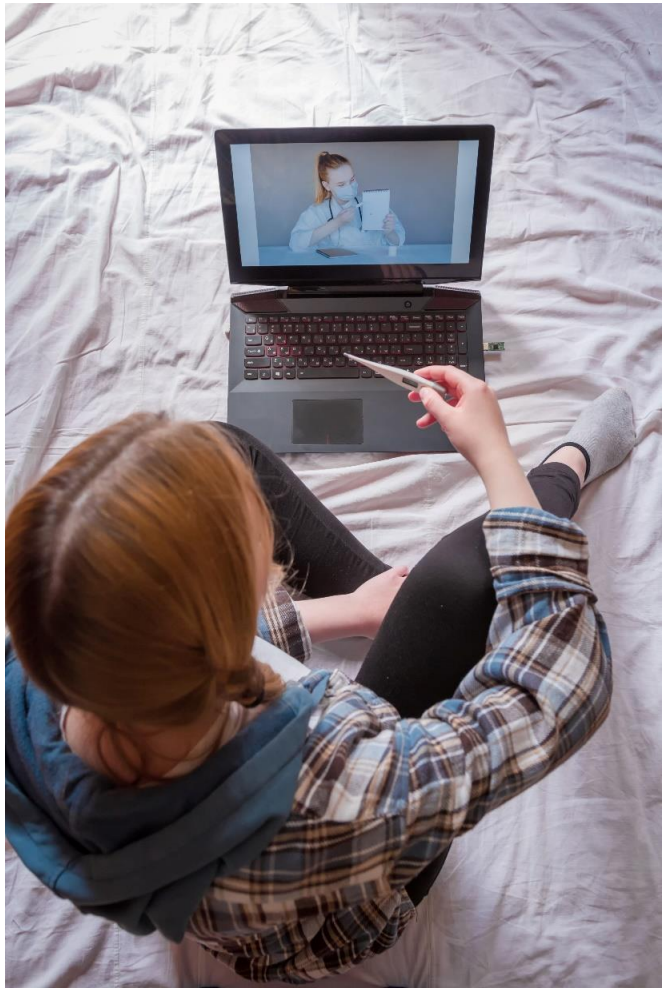
"Today people expect omnichannel access to care and adding telehealth to our Walmart Health care strategies allows us to provide in-person and digital care across our multiple assets and solutions."

Cheryl Pegus, MD, executive vice president of health and wellness at Walmart

Source: Becker's Hospital Review, *Walmart to bring telehealth nationwide with acquisition of MeMD: 8 details,* Jackie Drees and Hannah Mitchell, 5/6/21 https://www.beckershospitalreview.com/telehealth/walmart-health-to-acquire-telehealth-provider-6-details.html?origin=CIOE

Call to Action: Amazon Expands Amazon Care, Moving Into Primary Care Outside Its Workforce

- Amazon announced the expansion of Amazon Care, its first primary care offering accessible by non-Amazon employees.
- Until now, Amazon Care has been available only to Amazon employees in Washington State. It is now available to employees in every state and will be available to non-Amazon nationwide later this year.
- Amazon care has two components
  - Telemedicine
  - In-person care, where a professional is dispatched to a patient's home
- June 11th Update (Fierce Healthcare): Amazon reports having signed multiple corporate accounts as part of national expansion of Amazon Care



Source: https://www.aboutamazon.com/news/workplace/amazon-care-to-launch-across-u-s-this-summer-offering-millions-of-individuals-and-families-immediate-access-to-high-quality-medical-care-and-advice-24-hours-a-day-365-days-a-year; https://www.modernhealthcare.com/information-technology/amazon-jumps-healthcare-telemedicine-initiative?utm_source=modern-healthcare-am-Thursday; https://www.beckershospitalreview.com/strategy/amazon-care-has-its-first-enterprise-client.html

Call to Action – Declining OP Volume

In 2018, US hospital outpatient visits declined for the first time since 1983, specifically in the number of emergency outpatient visits

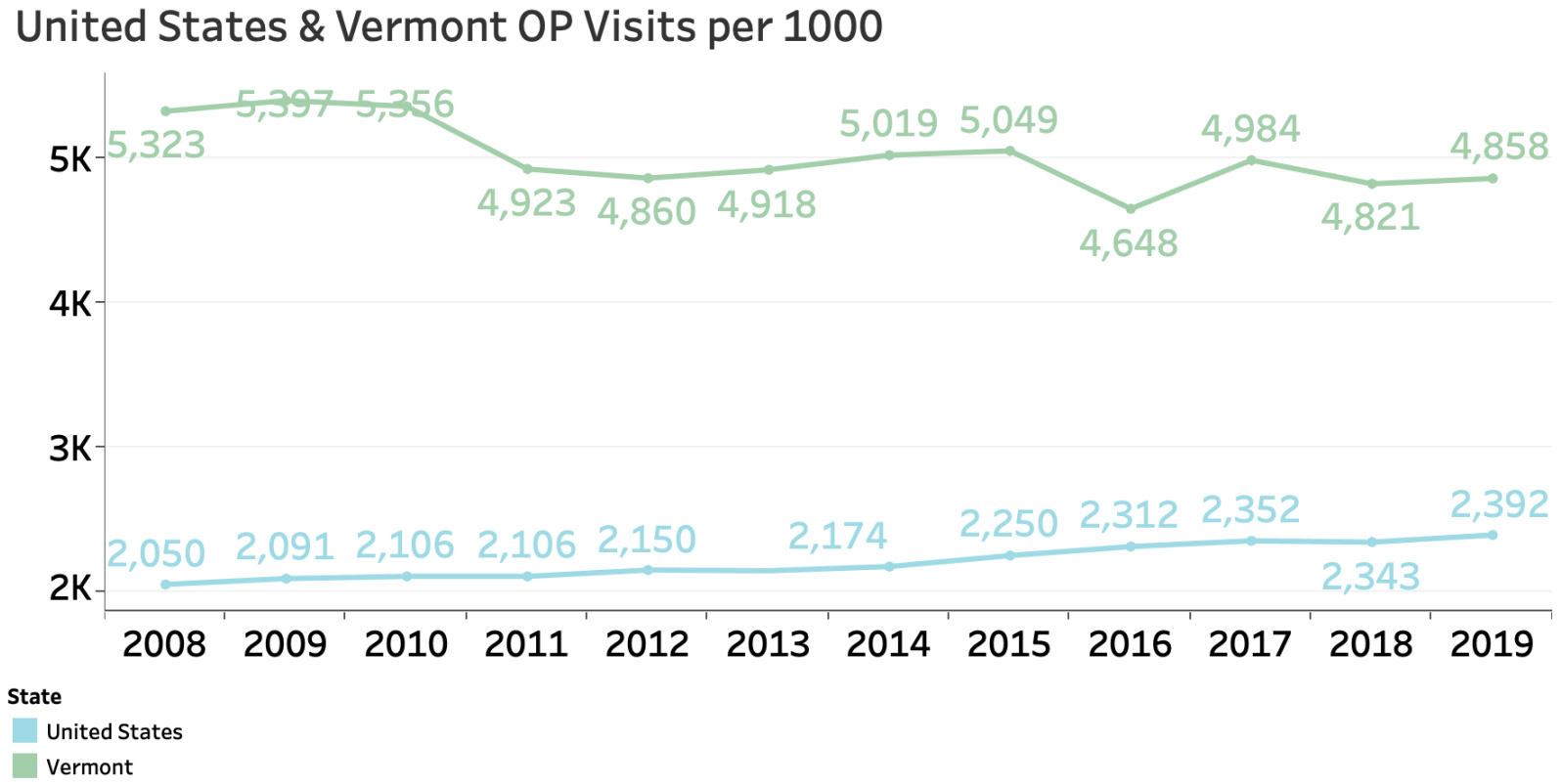
Per the American Hospital Association's 2020 Hospital Statistics report, 6,146 US hospitals delivered 879.6 million outpatient visits in 2018, 0.9% less than in 2017, when they delivered 880.5 million outpatient visits

The report cites that the amount of outpatient care delivered has most likely increased, but that care is being delivered in competitive new options such as urgent care centers and retail clinics such as those recently launched by CVS Health

Insurers have contributed to the trend, with UnitedHealthcare recently refusing to pay for certain outpatient surgeries in hospital settings to save money

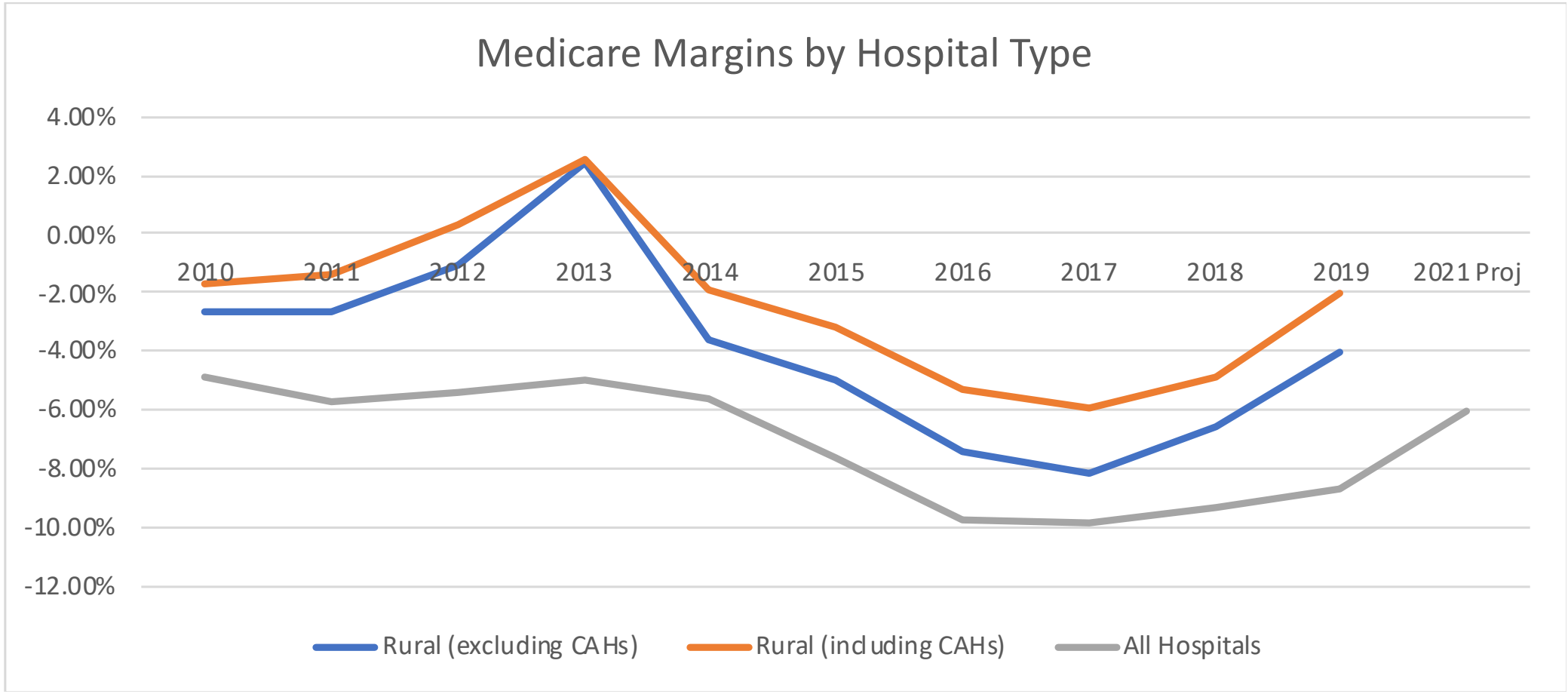
Source: Modern Healthcare, *U.S. hospitals see first decline in outpatient visits since 1983,* Tara Bannow, 1/7/20, https://www.modernhealthcare.com/operations/us-hospitals-see-first-decline-outpatient-visits-1983?utm_source=modern-healthcare-am-wednesday

Call to Action – Declining VT OP Volume



Source:KFF.org
Data are for community hospitals, which represent 85% of all hospitals. Federal hospitals, long term care hospitals, psychiatric hospitals, institutions for the mentally retarded, and alcoholism and other chemical dependency hospitals are not included.

Call to Action: Declining Medicare Margins



Source: MedPAC Report to Congress, March 15, 2021

New CMMI Director Dr. Liz Fowler on "Strategic Refresh" (4/25/21)

"WE NEED TO FIND A WAY TO BRING EVERYONE ALONG. WE CAN'T HAVE FEE-FOR-SERVICE REMAIN A COMFORTABLE PLACE TO STAY."

"We need to have a clear path for the innovators who are ready and willing and able to take on…risk, but I think we also need to push the laggards and then we need to reach those who have challenges participating….It may not be one-size-fits-all."

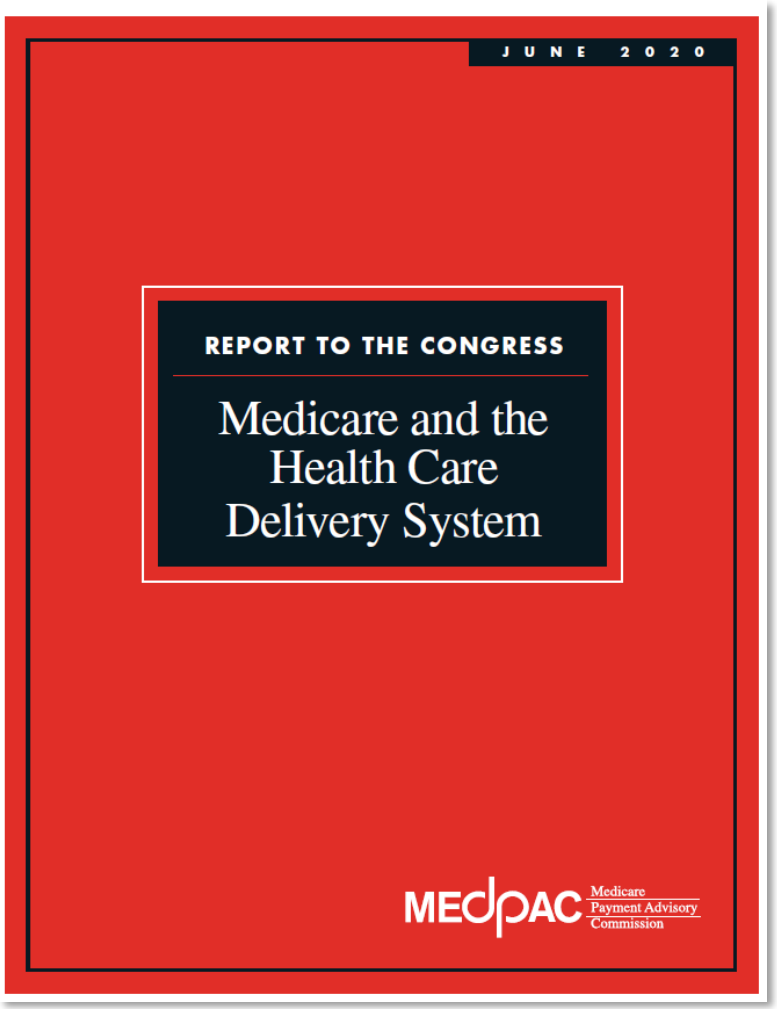
On CMMI innovation models: "A lot of what we've done has been aimed toward certification of models to become a permanent part of Medicare….In trying to get a model certified, it really does suggest a very specific model and a very specific way of thinking about evaluations and the assessment by actuaries. I wonder if we can instead think about the overall goal being transformation of the system instead of certification, or both."

Center for Medicare & Medicaid INNOVATION

Fowler asked for patience **"as we take time to review the portfolio of models, make adjustments where necessary and make sure that our path forward is sustainable and meaningful."**

June 2020 MedPAC Annual Report: Major Considerations

- **Realizing the promise of value-based payment in Medicare: An agenda for change.** The Commission outlines a multiyear effort to lay out a strategic direction for Medicare payment policy and delivery system design that broaden the use of value-based payment.
- **Challenges in maintaining and increasing savings from accountable care organizations (ACOs).** The Commission evaluates past savings, examines strategies to increase savings, and recommends a technical change that will reduce the risk that program vulnerabilities might result in unwarranted shared savings payments to ACOs.
- **Replacing the Medicare Advantage quality bonus program.** Medicare's quality bonus program (QBP) for assessing and rewarding quality performance in the Medicare Advantage (MA) program is flawed and not consistent with the Commission's principles for quality incentive programs. In this report, the Commission recommends that the Congress replace the QBP with an MA–VIP that includes five key design elements.



Source: *Report to the Congress: Medicare and the Health Care Delivery System,* MedPAC, June 2020 http://www.medpac.gov/docs/default-source/reports/jun20_reporttocongress_sec.pdf?sfvrsn=0

Call to Action

- Traditional fee-for-service payment will continue to transition to value-based payment
- Pressure for operational efficiencies and human and capital resources will continue to accelerate
- Clinical integration will create advantages to systems of accountable care (Value based payment, re-admission rates and preventable re-admissions, bundled payments, accountable care organizations, etc.)
- Flexibility must be ingrained into any short to medium term strategies as a direct result of increased regulatory and environmental uncertainty

Future Hospital Financial Value Equation

- Definitions
  - Patient Value

$$\text{Patient Value} = \frac{\text{Quality}}{\text{Cost}} \text{ X Population}$$

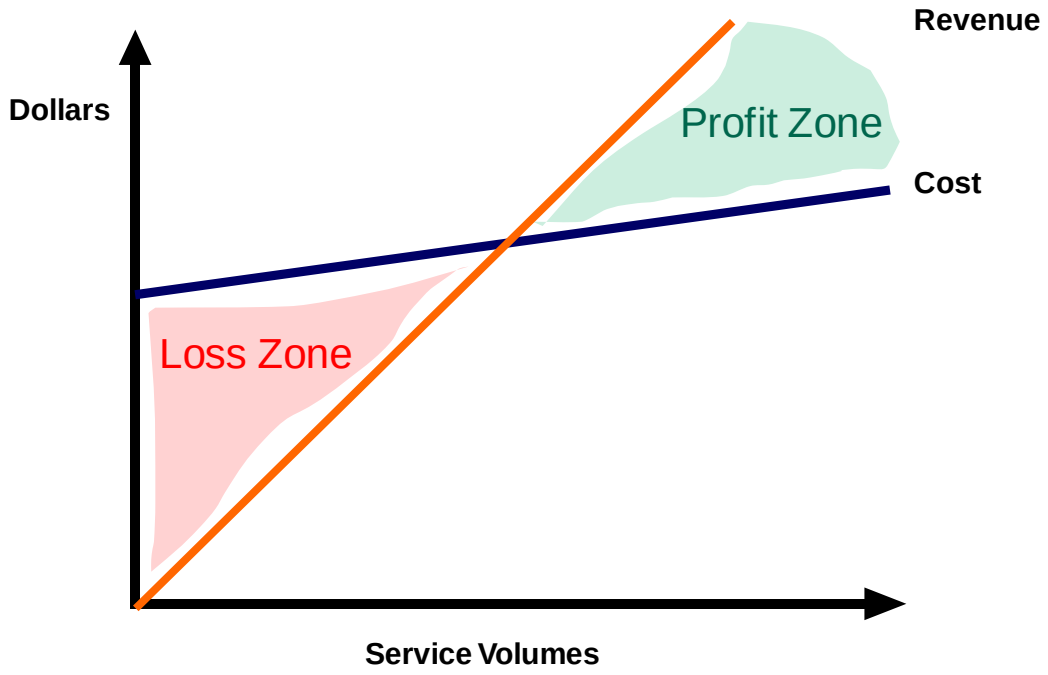
  - Accountable Care:
    - A mechanism for ***providers to monetize the value derived from increasing quality and reducing costs***
      - Accountable care includes many models including bundled payments, value-based payment program, provider self-insured health plans, Medicare defined ACO, capitated provider sponsored healthcare, etc.
    - Different “this time”
      - Providers monetize value
      - Government “All In”
      - New information systems to manage costs and quality
      - Agreed upon evidence-based protocols
      - Going back is not an option

Future Hospital Financial Value Equation

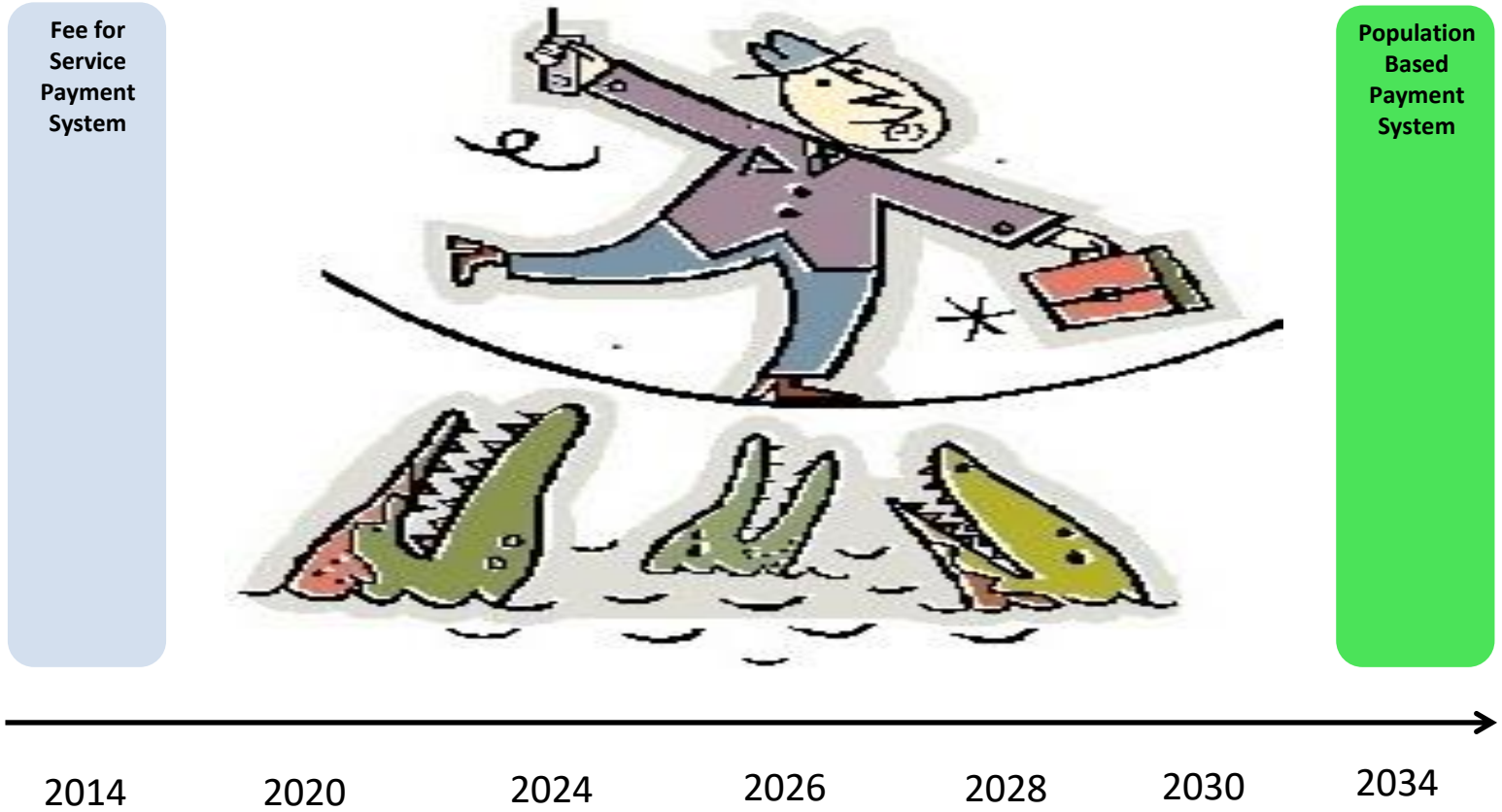
- ACO Relationship to Small and Rural Hospitals
  - Revenue stream of future tied to Primary Care Physicians (PCP) and their patients
  - Small and rural hospitals bring value / negotiating power to affiliation relationships as generally PCP based
    - Smaller community hospitals and rural hospitals have value through alignment with revenue drivers (PCPs) rather than cost drivers but must position themselves for new market:
      - Alignment with PCPs in local service area
      - Develop a position of strength by becoming highly efficient
      - Demonstrate high quality through monitoring and actively pursuing quality goals

Future Hospital Financial Value Equation

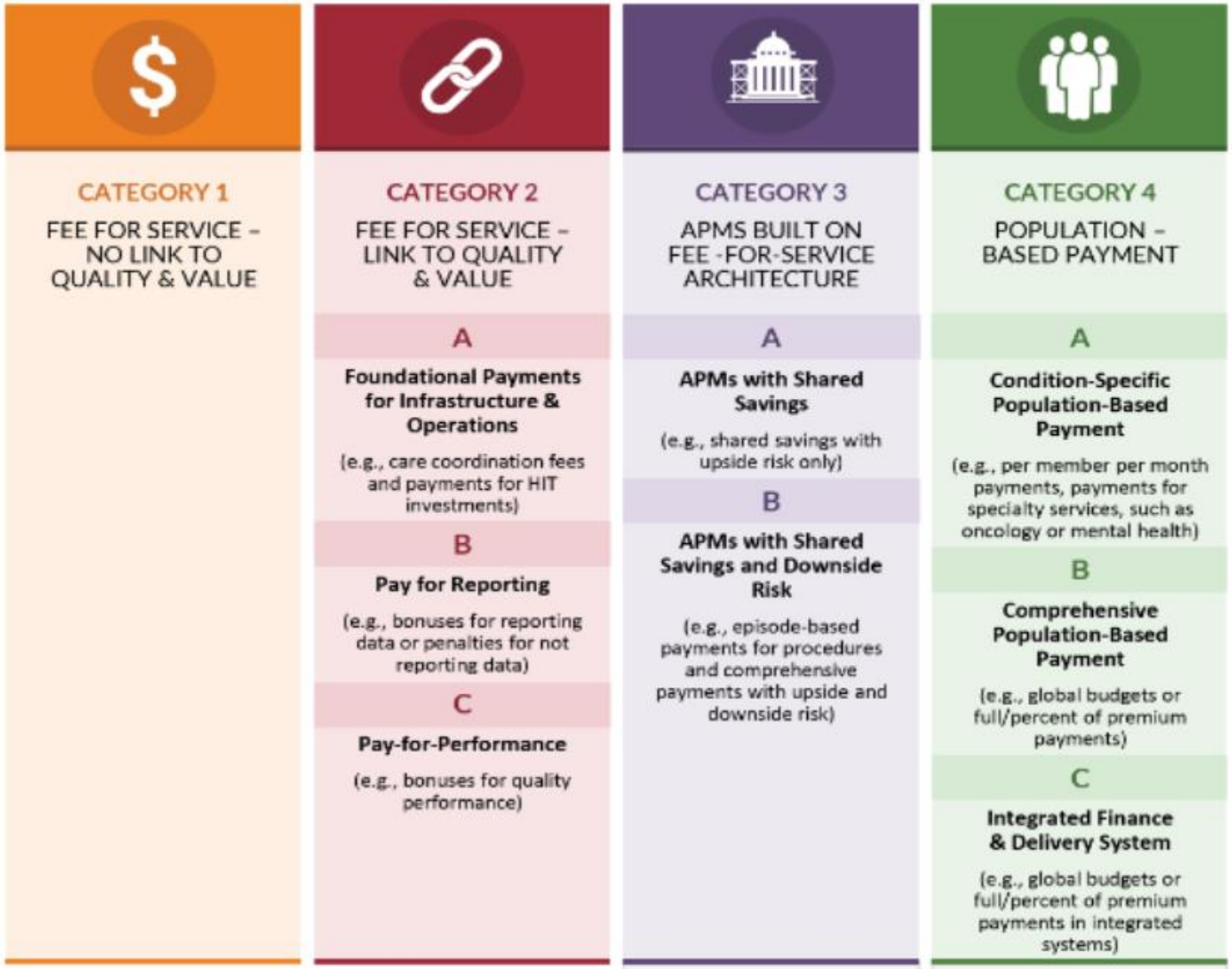
- Economics
  - As payment systems transition away from volume-based payment, the current economic model of increasing volume to reduce unit costs and generate profit is no longer relevant
    - New economic models based on patient value must be developed by hospitals, but not before the payment systems have converted
  - Economic model: FFS Rev and Exp VS. Budget Based Payment Rev and Exp



The Challenge: Crossing the Shaky Bridge



Payment Transition – CMMI (Dr. Rajkumar 3/2016)



The Premise

Macro-economic Payment System

- Government Payers
  - Changing from F-F-S to PBPS
- Private Payers
  - Follow Government payers
  - Steerage to lower cost providers

Provider Imperatives

- F-F-S
  - Management of price, utilization, and costs
- PBPS
  - Management of care for defined population
  - Providers assume insurance risk

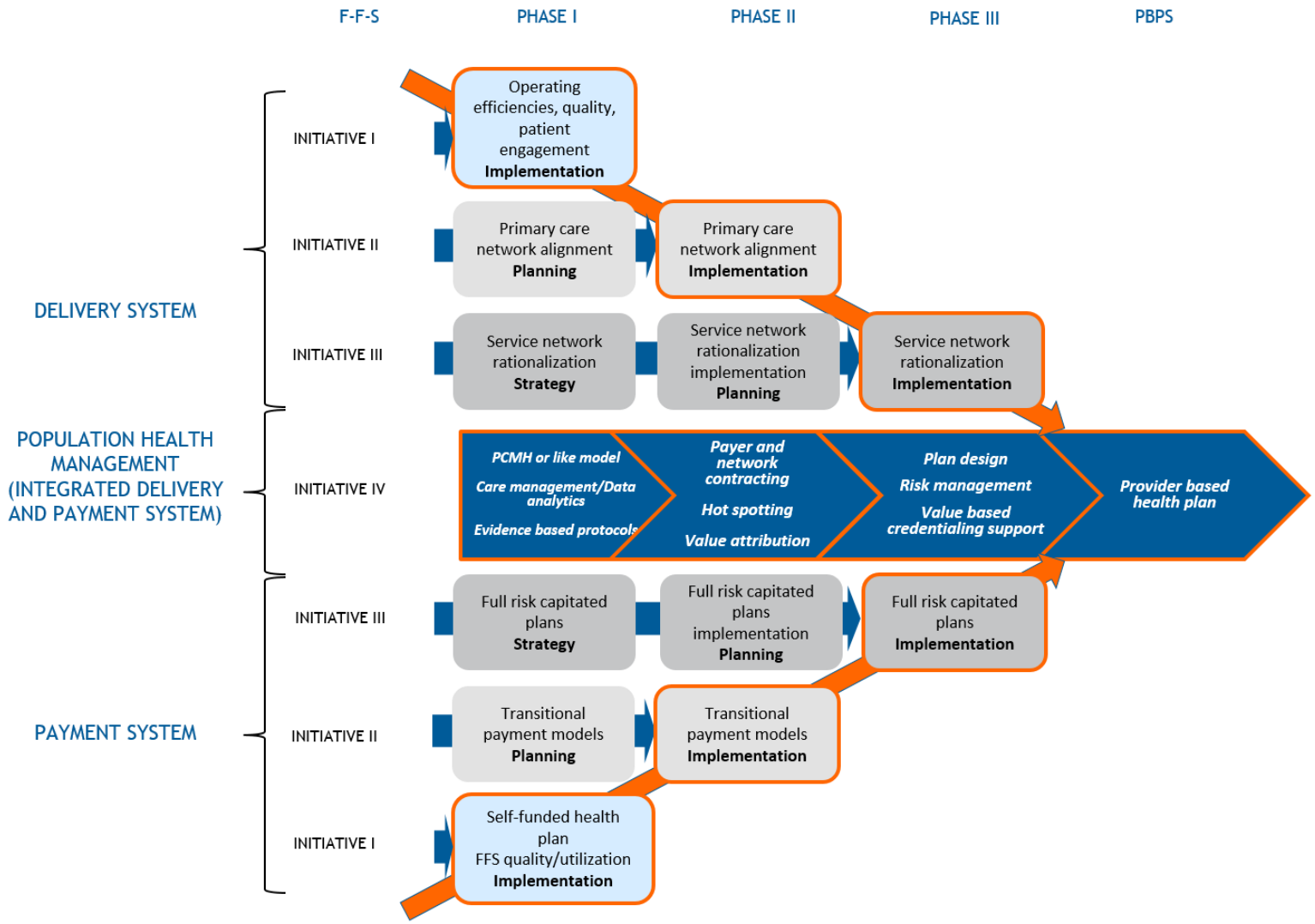
Provider organization

- Evolution from
  - Independent organizations competing with each other for market share based on volume to
  - Aligned organizations competing with other aligned organizations for covered lives based on quality and value

Network and care management organization

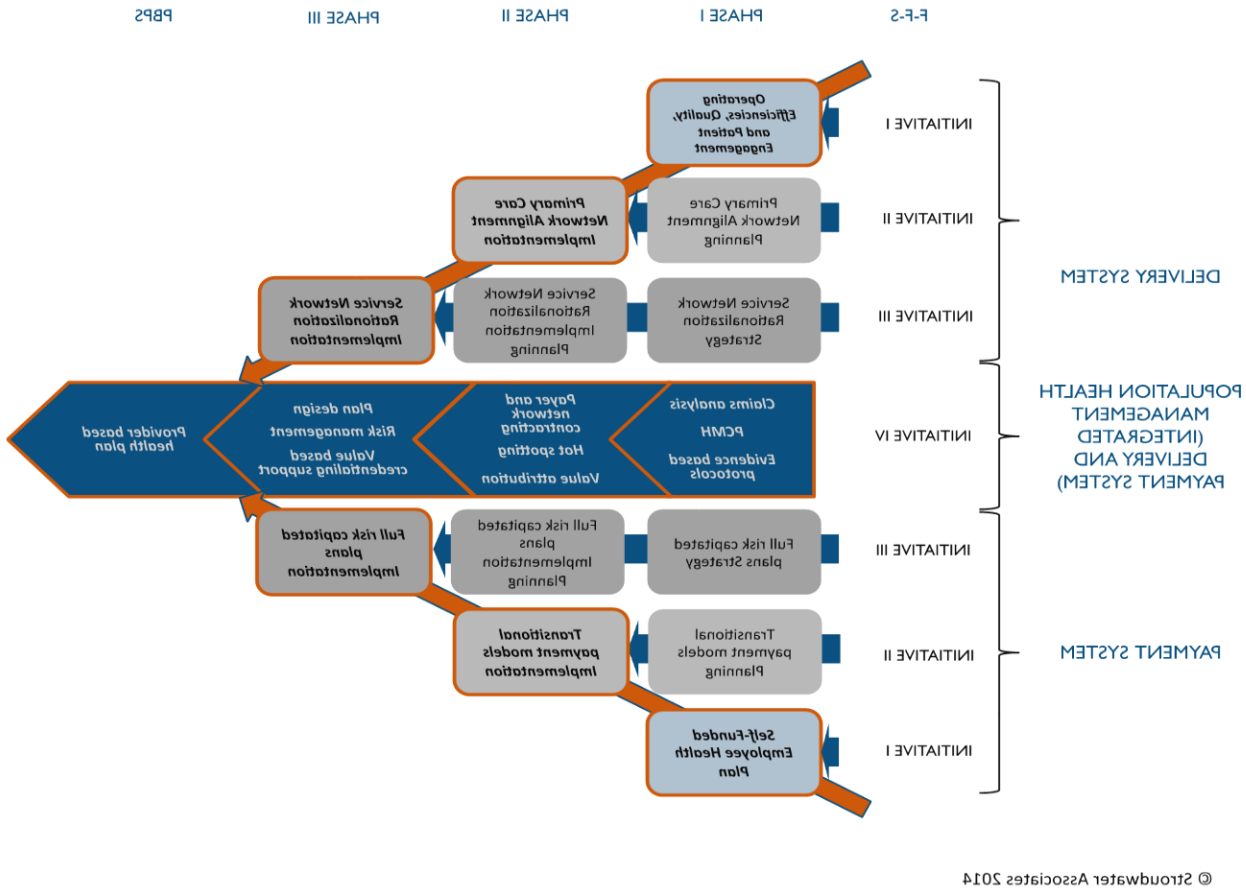
- New competencies required
  - Network development
  - Care management
  - Risk contracting
  - Risk management

Transition Framework – What Is It?

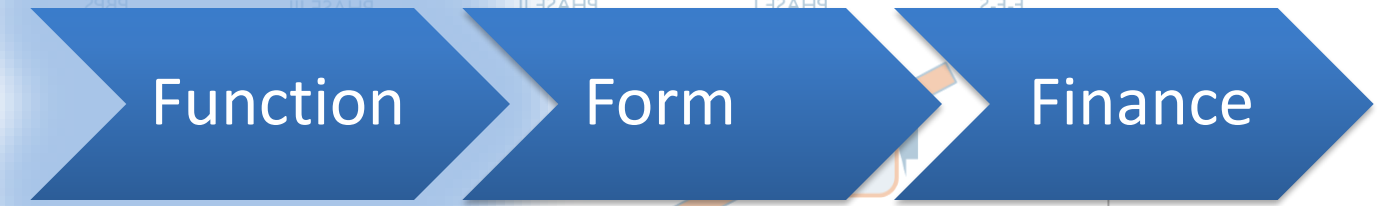


Vermont Healthcare 2030

- Vision:
  - *Vermont health systems partner with community to improve health while preserving appropriate access to patient care – flipping the plan*

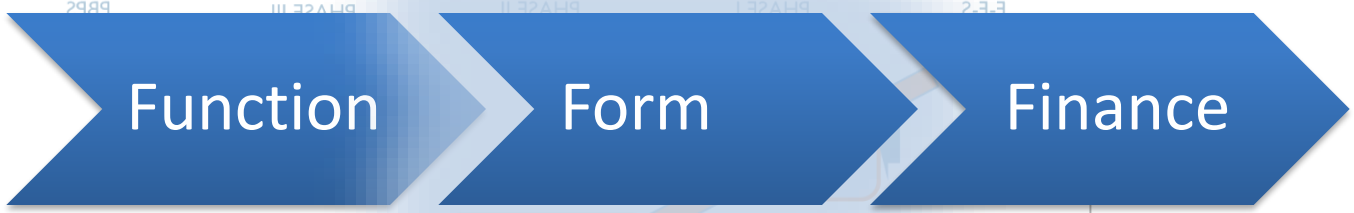


Vermont Healthcare 2030



- Function
  - Health systems partnering with community to improve health of a defined population with preserving appropriate access to traditional care
    - Chronic disease management
    - Increased relevance of health system in healthcare
  - Access to appropriate and right-sized traditional patient care
    - Right care, right time, right place, right provider
    - Common evidenced based protocols
    - Quality and patient safety are critical
- Requirements:
  - Common vision for healthcare of Vermont
  - Payment system that provides incentives for healthcare

Vermont Healthcare 2030

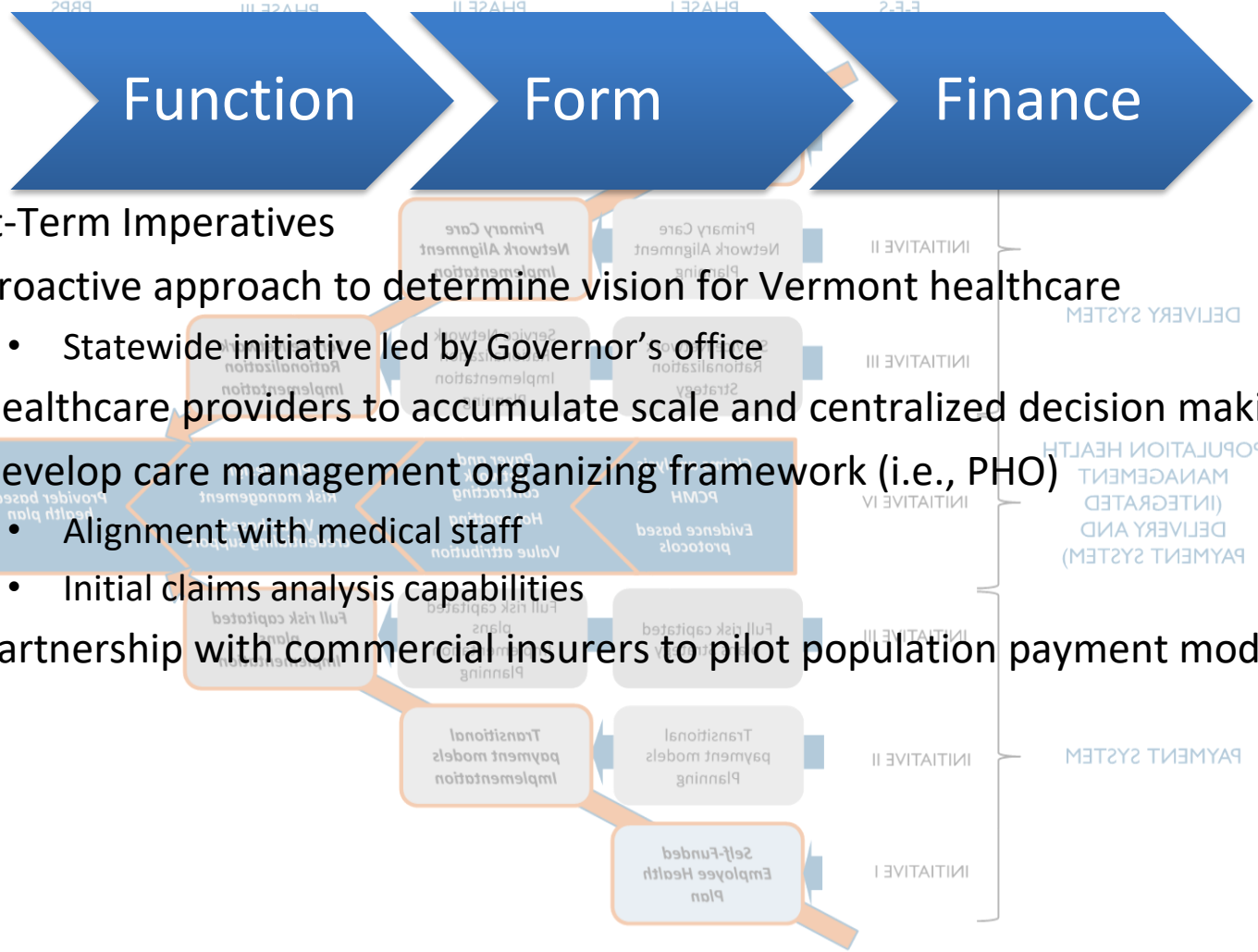


- Form
  - Aligned providers
    - High level of integration
    - Non-traditional partners (Public health, Mental health, Wellness, etc.)
    - Primary care with patient attribution
  - New roles for health systems
    - Claims analysis, network contracting, risk management, risk contracting
  - Integration of payment and delivery system functions
  - Requirements
    - Patient lives to diversify insurance risk
    - Centralized decision making to appropriate “right-size” delivery system
    - Common information technology platform

Vermont Healthcare 2030

- Finance
  - Payment must fund necessary access to healthcare while preserving traditional patient care
    - Payment incentives cannot preclude health interventions
    - Payment incentives cannot preclude access to appropriate patient care
  - Financial reporting to reflect “income” for both healthcare and sick care
- Requirements
  - Nearly 100% global payment to healthcare providers based on attributed population
    - May require healthcare providers to assume insurance risk
  - Financial reporting methods to be adopted to new payment methodologies
    - “Credit on income statement” for improved population health
  - New “cost centers” are provided budgets to manage within

Vermont Healthcare 2030



- Short-Term Imperatives
  - Proactive approach to determine vision for Vermont healthcare
    - Statewide initiative led by Governor's office
  - Healthcare providers to accumulate scale and centralized decision making
  - Develop care management organizing framework (i.e., PHO)
    - Alignment with medical staff
    - Initial claims analysis capabilities
  - Partnership with commercial insurers to pilot population payment models

Vermont Environment – Transformational Efforts

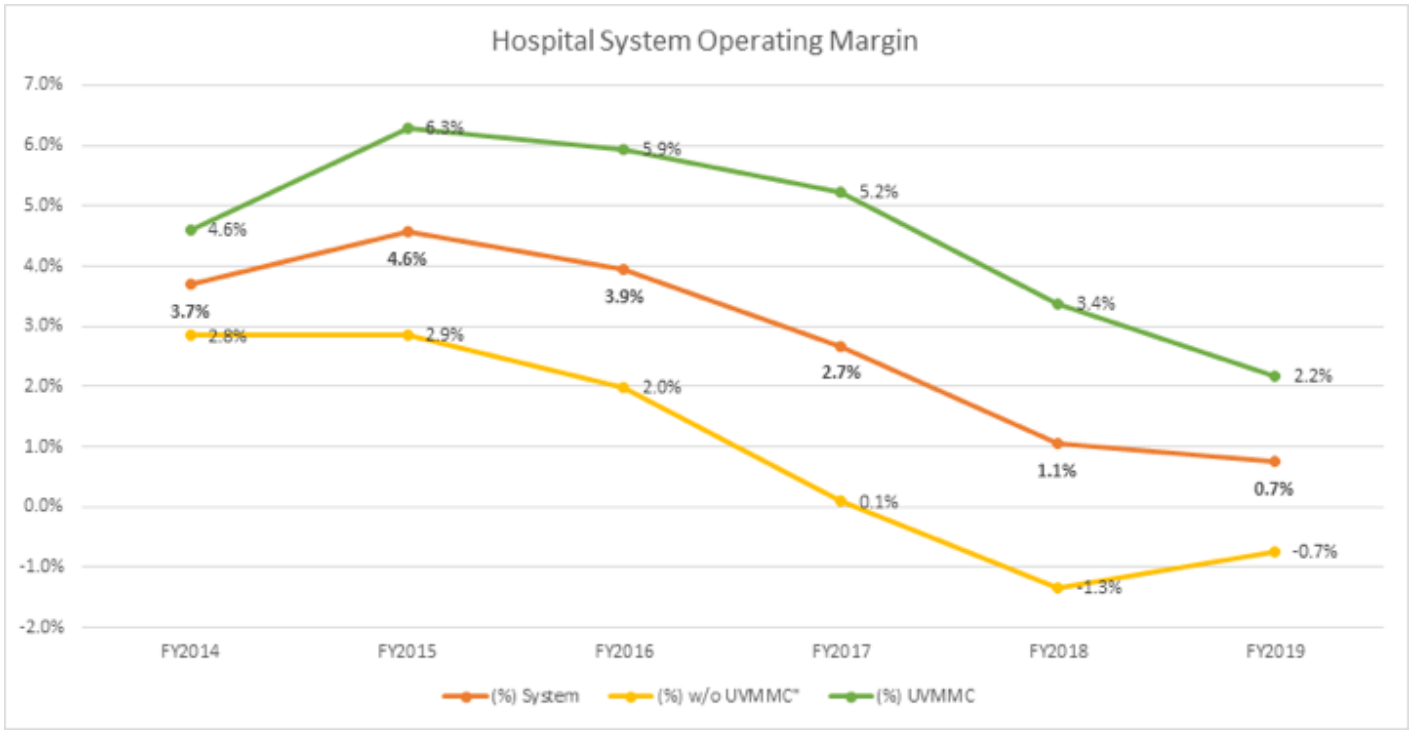
- Statewide Transformational Efforts
  - Blueprint for Health
    - Launched in 2003 as a unit within department of Department of Vermont Health Access (DVHA) with mission of "integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management."
    - Programs include Patient Centered Medical Homes (PCMH), Community Health Teams (CHT), Hub and Spoke Medication Assisted Treatment (MAT), and Women's Health Initiative (WHI)
    - Makes payment decisions about PCMHs and CHTs for Medicaid and Commercial insurers
  - Green Mountain Care Board (GMCB)
    - Independent five-member board, created in 2011 through VT legislature with a goal to promote the general good of the State by improving the health of the population, reducing per-capita rate of healthcare cost growth, enhancing the patient and health care professional experience of care, recruiting and retaining high-quality health care professionals, and achieving administrative simplification in health care financing and delivery
    - Establishes and enforces revenue growth rates for 14 community hospitals and regulates hospitals' net patient revenue, fixed prospective payment growth, and charge setting
    - Act 159 of 2020: GMCB shall consider ways to increase financial sustainability of VT hospitals

Vermont Environment – Transformational Efforts

- Statewide Transformational Efforts (continued)
  - VT All-Payer ACO Model Agreement (5-year CMMI demonstration program ending 2022)
    - 5-year (2018-2022) demonstration arrangement between VT and CMS that allows Medicare to join Medicaid and commercial insurers to shift payment from FFS to an alternative, value-based payment system
      - Accountable Care Organizations (ACOs) will be used as vehicle for changing payment
      - Goal is average cost growth of healthcare over the 5-year period at 3.5% and no more than 4.3%, while improving health care quality and the health of Vermonters
      - Increasing payer and provider participation (scale) is measured annually by counting the number of Vermonters that are covered by an insurer offering a qualifying ACO program
  - OneCare VT ACO
    - A community of healthcare providers driving system change and improvement by leveraging innovation, information, investment, access, and education
    - Only ACO in VT that contracts with Medicare, Medicaid and commercial insurers with nearly all health systems participating in APMs
      - Establishes TCOC targets with payers under both upside/downside (Medicare and Medicaid) or upside only (commercial plans)
      - Health system and provider participation in OneCare VT APMs is optional for each “program”

Vermont Environment - Providers

- 14 hospitals consisting of 1 AMC, 5 PPS hospitals and 8 CAHs
  - 3 hospitals in system relationship; 11 independent hospitals
  - BRG report suggests adequate bed capacity to meet needs of aging population with some incremental capacity necessary in 2026
  - Consistent decline in average operating margin between FY15 and FY19 with expenses outpacing revenue growth

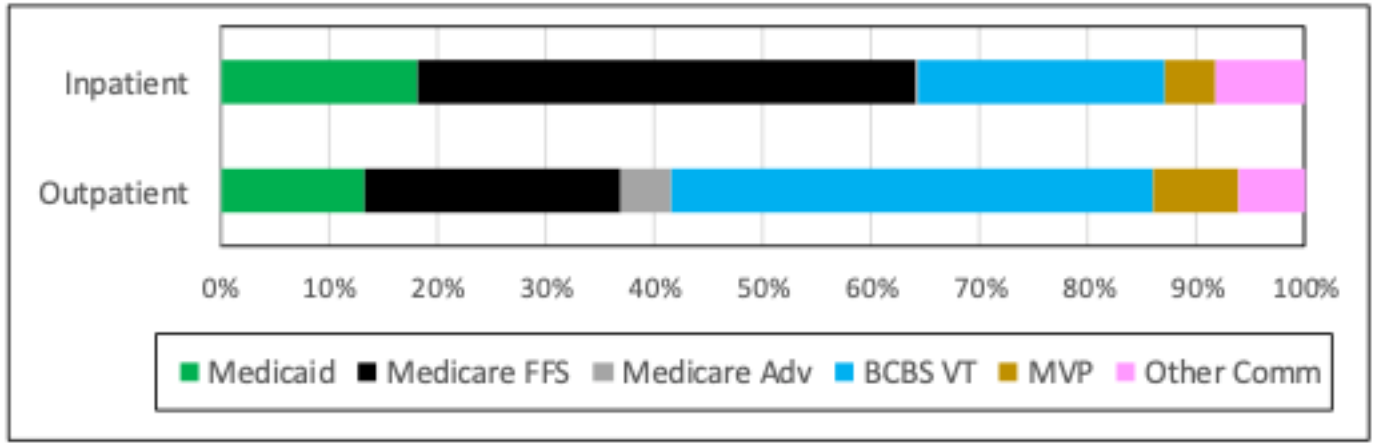


Source: GMCB Update on Act 159 of 2020, section 4: Hospital Sustainability Planning; April 1, 2021

Vermont Environment – Providers (continued)

- Primary Care Providers
  - Mix of employed and private practices with some operating as FQHCs and RHCs
    - Reported that a majority of providers are employed by health systems
    - Nearly all participating in patient centered medical homes with some payment in PMPM

Vermont Environment - Payers



Source: GMCB internal analysis

- Commercial/Self Funded
  - Collectively represents 36% of hospital IP payment and 58% of hospital OP payment
  - Reported significantly higher IP and OP commercial payment rates than Medicare and Medicaid which results in providers prioritizing FFS payment mechanisms to maintain operating margin
  - BC/BS VT and MVP participate with OneCare VT ACO through shared savings program only with health plans contributing $3.25pmpm to OneCare VT to support population health management activities
    - Payers pay providers directly based on FFS claims with year-end settlement with OneCare VT based on actual claims experience relative to pre-determined TCOC budget
    - Shared savings with OneCare VT based on 50-50 split
    - BC/BS VT has one pilot program with a health system whereby the health system receives a monthly fixed payment with no reconciliation to claims

Vermont Environment - Payers

- Commercial/Self Funded (continued)
  - Self funded health plans represent a significant portion of commercial insurance
    - BC/BS VT acts as third-party administrator (TPA) for a portion of these self-insured health plans
    - Reported that individual self funded health plans are generally not sophisticated at developing value-based payment arrangements with OneCare VT

Vermont Environment - Payers

- Medicare
  - Collectively represents 46% of hospital IP payment and 29% of hospital OP payment
  - Hospitals can elect to participate in All-Payer ACO which results in them accepting risk tied to their covered lives
    - OneCare VT ACO accepts 100% risk within a 5% risk corridor
    - Reported that 8 VT health systems participating in Medicare ACO for FY 2021
      - CAHs paid on a cost-basis with settlement to cost report while PPSs and AMCs paid on a fee schedule
      - Hospitals are not required to participate in ACO
      - Barrier to rural hospitals participating in the All-Payer ACO is their inability to accept risk for their covered lives
    - Participating hospitals can elect to receive either FFS payment or a fixed monthly payment, with yearend reconciliation and settlement to claims
  - Independent primary care providers can participate in Comprehensive Payment Reform (CPR) in which providers receive a monthly Per Member Per Month (PMPM)
    - Reported that nearly 50% of independent primary care practices are participating in CPR

Vermont Environment - Payers

- Medicaid
  - Collectively represents 18% of hospital IP payment and 12% of hospital OP payment
  - Fix hospital payment to OneCare VT for all Medicaid lives, with OneCare VT paying hospitals a fixed, capitated payment based on attributable lives
  - Total cost of care (TCOC) negotiated between OneCare VT and VT Department of Health Access (DVHA) with risk/Reward corridor of 4%
    - Attributable Medicaid lives have increased from 29K in 2017 to 111K in 2021
    - Risk/reward is based on FFS payments relative to budget, which are approximately 50% of the TCOC
  - Like Medicare, independent primary care providers can elect to participate in CPR

Vermont Environment – Observations/Opportunities

- Observations
  - VT is the leader of all states in the transformation from “sick care” to healthcare
    - Vision established with buy-in from highest level of state government, providers, and payers
    - Payment system aggregator (OneCare VT) enables consistent payment to all providers
  - Comprehensive payment system reform well underway, however challenges
    - Small and rural hospitals, generally paid between 30-40% of TCOC are unable to accept risk on TCOC
    - Commercial plans requiring 50-50 gain share with no downside risk, along with payment to providers based on FFS claims promotes FFS payment
      - On average, health systems fixed to variable cost ratio of 80-20 requiring gain share of at least 80-20 to provide appropriate incentives
    - For a majority of providers, FFS payment exceeds 20% of total payment thus providing incentives for all payer ”sick care” volume
    - Optional health system and independent provider enrollment in APMs based on ”programs”

Vermont Environment – Observations/Opportunities

- Considerations
  - Highest level of State to participate in developing vision
  - Target 2030 for full transformation of payment system
    - Gives health systems and providers adequate time to develop meaningful investments in health-related activities while maintain access to high quality “sick-care”
  - OneCare VT to aggregate nearly all-payer payment and channel to providers
    - Health systems required to participate in all “programs”
    - Primary care practices required to participate in Comprehensive Payment Reform
    - Transition nearly all health system payment away from claims payment/reconciliation towards fixed, budgeted payment
      - Critical Access Hospitals transition from cost-based payment to budget-based payment
    - TCOC shared savings/risk arrangement for all payers
      - May require provider withholds
    - OneCare VT, as statewide vehicle for payment change, must have boarder governance representation
  - GMCB to actively participate in setting aggregate TCOC and provider budgets as well as ensuring high quality and community investment in health-related activity

Conclusions/Recommendations

- The FFS payment system – designed to pay for "sick care" – precludes incentives or payment for meaningful investment in "health care" activities, programs, or infrastructure
  - Currently, the "function" of health care is dictated by "finance" as the fee-for-service payment system was designed to pay for episodes of "sick care"
- A healthcare system that starts with the optimal "function" of healthcare requires both:
  - Patient access to high quality "sick care" and
  - Investment in health and wellness activities, program, and infrastructure to generate "health care"
- A Global Budget payment system maintains a predictable and steady revenue stream so a local health system can maintain access to high quality "sick care" while investing in community health
- A Shared Savings incentive payment provides the funds to invest in "health care"
- With some changes, VT has necessary infrastructure in place to develop a true healthcare system

Eric K. Shell, MBA
Eshell@stroudwater.com
1685 Congress Street, Suite 202
Portland, Maine 04102
(207) 221-8252

www.stroudwater.com